RESTORE HEALTH
INFUSION AND WELLNESS

SPEVIGO

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB test

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ L40.1 (Generalized Pustular Psoriasis - GPP)

Allergies: _____ **Weight:** _____ ☐kg ☐ lbs **Height:** _____ ☐cm ☐ in

TB/PPD test: ☐Positive ☐Negative **HBV:** ☐Yes ☐No If yes, treated: ☐Yes ☐No

TREATMENT

SPEVIGO (spesolimab-sbzo)

Route: Intravenous Infusion

Dose: ☐ 900mg

Frequency:

☐ Single dose

If GPP flare symptoms persist, an additional 900mg dose may be administered one week after the first dose. Subsequent treatments may require insurance authorization. New order required for every additional dose.

Quantity: _____ Refills: _____

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐25mg ☐50mg ☐PO ☐IV

☐ Acetaminophen: ☐325mg ☐500mg ☐650mg PO

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

Provider Signature: _____ Date: _____